DEPARTMENT OF HEALTH AND H AN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

45th 4/10/11

PRINTED: 03/01/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445228	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	02/22/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF GREENEVILLE	725 CRUM STREET GREENEVILLE, TN 37743

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 022 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Access to exits is marked by approved, readily visible signs in all cases where the exit or way to reach exit is not readily apparent to the occupants. 7.10.1.4 This STANDARD is not met as evidenced by: Based on observation the facility failed to assure exits were properly marked. The findings included: Observation on February 22, 2011 at 10:00 a.m. revealed the exit sign provided at the Aspen wing indicated the incorrect exit path.	K022	CORRECTIVE ACTION: All facility maintenance personnel were immediately in-serviced on NFPA 101 Life Safety Code Standards. RESIDENTS WITH POTENTIAL TO BE AFFECTED: All Facility residents and visitors have the potential to be affected. SYSTEMIC CHANGES: All facility maintenance personnel were in-serviced on NFPA 101 Life Safety Code Standards on 2/22/11. Maintenance Director, or his designees, will make rounds to monitor daily compliance. MONITORING: Maintenance Director, or his designees, will make daily rounds to assure compliance through random daily rounds to assure exits are marked by approved readily visible signs in all case where exits or way to reach exit is not readily apparent to the occupants. The Executive Director and/or their designee will assure compliance by making random daily rounds. Findings from the rounds will be reported to the facility's Executive Director and reported monthly to the Quality Assurance/Performance Improvement Committee for 3 months, the Quality Assurance/Performance Improvement Committee will review information for need of further observation.	4/10/11
K 039 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Width of aisles or corridors (clear and unobstructed) serving as exit access is at least 4 feet. 19.2.3.3 This STANDARD is not met as evidenced by: Based on observation the facility failed to assure corridors were maintained clear and unobstructed. The findings included:	K039	CORRECTIVE ACTION: All facility personnel were in-serviced on maintaining clear and unobstructed aisles and corridors.	4/10/11

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Jennifer C Solomon, MA Executive Director 03/10/11

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K 039	Continued From page 1 Observation on February 22, 2011 between 10:00 a.m. and 2:00 p.m. revealed corridors obstructed by 4 clean linen carts, 2 hoya lifts, 4 med carts and 4 soiled linen containers.			
K 062 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on observation the facility failed to assure sprinkler systems were maintained in reliable operating condition. The findings included: Observation on February 22, 2011 at 11:30 p.m. revealed 7 sprinkler heads were obstructed by light fixtures and storage was closer than 18 inches to a sprinkler head in the therapy storage.		RESIDENTS WITH POTENTIAL TO BE AFFECTED: All facility residents have the potential to be affected. SYSTEMIC CHANGES: All facility personnel were in-serviced on 2-22-11 and 3-3-11 to assure that aisles and corridors are clear and unobstructed. The Maintenance Director, and/or designee will assure compliance through random daily rounds to assure the aisles and corridors are clear and unobstructed. MONITORING: Department Heads, or their designees, will perform rounds daily to monitor aisles and corridors and assure they are clear and unobstructed. The Maintenance Director and/or his designee will assure compliance through random daily rounds to assure the aisles and corridors are clear and unobstructed. Findings from the rounds will be reported to the facility's Executive Director and reported monthly to the Quality Assurance/Performance Improvement Committee for 3 months, the Quality Assurance/Performance Improvement Committee will review information for need of further observation.	
K 064 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1. 19.3.5.6, NFPA 10 This STANDARD is not met as evidenced by: Based on observation the facility failed to assure fire extinguishers were provided as per NFPA 10.	**K062**	CORRECTIVE ACTION: a) On 2-22-11, the Maintenance Director called the Sprinkler Company to replace 7 sprinkler heads on the cedar wing that are obstructed by the light fixtures. They will be installed by 04-10-11.	**4/10/11**

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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K 064	Continued From page 2 The findings included: Observation on February 22, 2011 at 12:15 p.m. revealed the fire extinguisher in the clean equipment room was installed higher than 60 inches from the floor to the top of the handle.		b) All Rehab personnel were immediately in-serviced on appropriate storage of equipment in the therapy storage room. RESIDENTS WITH POTENTIAL TO BE AFFECTED: All facility residents have the potential to be affected. SYSTEMIC CHANGES: All rehab personnel were in-serviced on 2-22-11 and 3-3-11 on appropriate storage of equipment in the therapy storage room. The Maintenance Director, and/or the designee, will make random rounds to monitor daily compliance. MONITORING: The Maintenance Director, and/or his designee, will make rounds to monitor daily compliance and to assure the sprinkler system is maintained. The Executive Director and/or their designee will assure compliance by making daily random rounds. Findings from the rounds will be reported to the facility's Executive Director and reported monthly to the Quality Assurance/Performance Improvement Committee for 3 months, the Quality Assurance/Performance Improvement Committee will review the information for need of further observation.	